Chapter 12
Access to Services

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Chapter 12

Access to Services

The Access to Services chapter describes how adults age 60 and over and adults with disabilities can access the programs and services that meet their needs. Access can have a different definition for each individual seeking programs and services. Access can be defined as the extent to which the individual can obtain services at the time they are needed. Some individuals want to understand their options and how they can research the availability of services on their own either through using a resource directory or internet search. Other individuals need guidance to navigate the service system. Resource information, transportation, caregiver support, in-home services, and other factors all play a role in helping the individual determine the options that will best serve his/her needs. Access can also be the extent to which the program and/or service are available to as many individuals as possible. Access can range from any of the following: 1) being given a referral contact number; 2) being assessed for receiving services; or 3) being enrolled in services. This chapter will describe specifically how programs and services can be accessed by individuals needing services and provide a brief description of the services and programs available through the Tennessee Commission on Aging and Disability (TCAD) and the Area Agencies on Aging and Disability (AAAD). The AAAD serve adults age 60 and over and adults with disabilities.

Area Agency on Aging and Disability (AAAD)
Serving as Aging and Disability Resource Center (ADRC)

12-1: Description of the Aging and Disability Resource Center (ADRC)

The Area Agencies on Aging and Disability (AAAD) serve as the Aging and Disability Resource Centers (ADRC) in Tennessee for adults age 60 and over and adults with disabilities to access services and programs to meet their needs. The ADRC concept is a collaborative effort of the Administration on Community Living (ACL) which includes the Administration on Aging; the Centers for Medicare and Medicaid Services (CMS); and the Veterans Health Administration (VHA). The ADRCs are known to be "no wrong door" or a "single entry point" and are designed to serve as highly visible and trusted places where people of all ages, incomes and disabilities get information and one-on-one counseling on the full range of long-term services

and supports. Thirty-three states have ADRC coverage for all or nearly all of their residents and 535 ADRCs are open across the country in 53 states and territories.

Statewide the nine (9) Area Agencies on Aging and Disability (AAAD) serve as the ADRC, the "single point of entry" for the services provided through the Older Americans Act, state-funded OPTIONS for Community Living Program (OPTIONS), federally funded State Health Insurance Assistance Program, and TennCare Choices home and community based services. The OPTIONS and SHIP programs and services accessed through the AAAD are described in additional chapters in the Program and Policy Manual.

12-1-.01: Fully Functioning Aging and Disability Resource Center (ADRC)

The Aging and Disability Resource Center (ADRC) Program serves as a "no wrong door" into the long-term supports and services system for adults age 60 and over and adults with disabilities. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, counseling and assistance, empower people to make informed decisions about their long-term supports, and help people more easily access public and private long-term supports and services programs. The Program Components/Core Functions of a fully functioning ADRC include (See Appendix A for further information):

(1) Information, Referral and Awareness

The information, referral, and awareness function of the ADRC serves as a highly visible and trusted place where individuals needing long-term services and supports can receive objective and unbiased information on the full range of available services and promote awareness of the various options that are available. ADRC should have the capacity to link individuals with needed services and supports, both public and private, through appropriate referrals to other agencies and organizations.

(2) Options Counseling

Options Counseling utilizes a person-centered approach, focusing on the individual and his/her strengths, capacities, preferences, and desired goals. Options Counseling provides one-on-one assistance and decision support to help the individual (and the caregiver, if appropriate) understand and assess his/her situation, and assist him/her in making informed decisions about long-term supports and services. The Options Counselor works with the individual to develop an action plan and, if requested,

arranges for the delivery of supports and services. Individuals should be able to make support and service choices that optimally meet his/her needs and preferences and use their own personal and financial resources efficiently and effectively.

(3) Streamlined Eligibility Determination for Public Programs

The Streamlined Eligibility Determination for Public Programs component serves as the "no wrong door" to all publicly funded long-term supports, including those funded by TennCare (State Medicaid Agency); the Older Americans Act (OAA); the Rehabilitation Services Act; and other state and federal programs and services. For "no wrong door" to be effective, protocols and procedures are essential to facilitate and/or coordinate the following functions:

(a) individual screening;

(b) assessing the individual's needs;

(c) determining programmatic, functional/clinical, and financial eligibility;

(d) developing an action plan;

(e) ensuring that the individual receives the services for which he/she is eligible; and

(f) assisting the individual in finding services unavailable in the traditional aging and disability network.

The process should be administratively efficient and seamless for the individual regardless of the program for which he/she is eligible or the type of service(s) received.

(4) Person-Centered Transition Support

Person-Centered Transitions component creates bridges between and among the major entities involved in the individual's support services as s/he moves from one service to another. The bridges may include formal linkages, such as a Memorandum of Agreement or contract. The bridges facilitate referrals from one agency or service to another, taking into consideration the individual's needs, resources, and preferences. The ADRC works to ensure that an individual understands his/her options and receives long-term supports and services in the setting that best meets the individual's needs and preferences.

(5) Consumer Populations, Partnerships and Stakeholders Involvement

In order to function efficiently and serve as the "no wrong door" for the full array of long-term supports and services in the state, the ADRC must have the documented

support and active participation of the TCAD (the State Unit on Aging), TennCare (the State Medicaid Agency), and the AAAD. Other state and community partnerships could include, but not be limited to, the Centers for Independent Living, State Health Insurance Assistance (SHIP) Program, the Veterans Health Administration (VHA), Adult Protective Services, Council on Developmental Disabilities, Long-term Care Ombudsman programs, Alzheimer's disease programs, other information and referral programs, housing agencies, and transportation authorities.

(6) Quality Assurance and Continuous Improvement

Quality Assurance and Continuous Improvement ensures 1) that services are available; 2) that the services are reliable and meet the needs of the individual; 3) that services are sustainable statewide; and 4) that services adhere to the program standards as indicated by policy. The ADRC will use electronic information systems to track their customers, services, performance measures, and costs and to continuously evaluate and improve on the results of the services that are provided to individuals, their families, and other community organizations. The ADRC will utilize a formal process for getting input and feedback from individuals and their families and will have measurable goals and indicators related to its visibility, trust, ease of access, responsiveness, efficiency and effectiveness.

12-1-02: Navigation of Resources

The AAAD/ADRC serves as the "no wrong door" for individuals and provides individuals with easy access to information, counseling, assistance, and linkages to a wide range of long-term support services and living options. The AAAD/ADRC is person-centered in its approach to working with the individual and can help the individual make informed decisions about his/her health care long-term services and supports, help the individual determine eligibility for available programs, make arrangements for the services needed through available state/federal programs or private pay and facilitate connections with service providers to limit the need for the individual to go elsewhere or duplicate their efforts.

12-1-03: Marketing and Outreach

(1) Description of Outreach

Outreach within the framework of Access to Services has two (2) definitions.

(a) The first definition of "outreach" relates to the Criteria of Fully Functioning

ADRC. The AAAD/ADRC must have "a proven outreach and marketing plan". The outreach and marketing plan considers all of the populations to be served focusing on adults age 60 and over and adults with disabilities including culturally diverse groups, underserved and unserved populations, those at risk of nursing home placement, family caregivers and professionals. The AAAD/ADRC is actively involved in the community to increase awareness about services and programs that are available and to educate individuals about the long-term supports and services that will meet their needs.

Providing outreach includes providing information to large groups and the use of mass media. In addition, outreach activities may specifically include, but are not limited to, attending events or gatherings that are attended by adults age 60 and over and adults with disabilities; providing displays at meetings attended by agencies and organizations that serve the identified population; providing information for newsletters; advertising; and distribution of cards and/or pamphlets.

(b) The second definition is found in the *Service Taxonomy* of the Resource Database. Outreach is defined as "Agency initiated activities designed to identify and provide one-on-one contact with isolated older persons or their caregivers who have unmet service needs and to assist them in gaining access to appropriate services; delivered by agencies designated by the area agency with a defined responsibility and trained staff specifically assigned for providing this service." This definition of outreach in the Service Taxonomy "does not include contact with groups and use of mass media."

(2) Administrative Requirements

(a) TCAD shall:

(i) provide technical assistance for the outreach and marketing plan for dissemination of information about long-term supports and services; and

(ii) coordinate the outreach activities from the AAADs with TCAD's overall marketing plan.

(b) The AAAD shall:

(i) have a written targeting plan in the AAAD area plan to provide awareness

and education to priority populations such as low income, minorities, and rural populations, to all adults age 60 and over, adults with disabilities, individuals with limited English proficiency, and the underserved and vulnerable populations regardless of method of payment for those programs and services;

(ii) use a variety of communication strategies to actively provide information, awareness, and community education about programs and services to the general public and social services serving adults age 60 and over, adults with disabilities, and their caregivers;

(iii) encourage other community services agencies to promote and utilize the AAAD (ADRC);

(iv) communicate with local service providers, government officials, planning bodies, and other agencies and organizations working with the target population by participating in regularly scheduled city and/county board meetings, community resource fairs, scheduled meetings of community service providers, and other similar community oriented activities; and

(v) enter the data for all outreach activities in SAMS database.

12-1-04: Transportation

(1) Description of Transportation Services

In the ***Tennessee State Plan on Aging 2014-2018***, affordable, accessible, and safe transportation was identified as a major need in Tennessee. Goal 3 of the State Plan is to enhance transportation services that are easier to access for adults age 60 and over and adults with disabilities. Transportation resources are needed to meet activities of daily living, such as, but not limited to, shopping for groceries and other needs, medical and other health care related appointments, pharmacies, meal sites, and socialization. Adults age 60 and over and adults with disabilities rely on both public and private transportation, such as buses, taxis, volunteer drivers, and senior center vans. In addition, transportation for many of the medical issues impacting these populations, such as dialysis, is not usually flexible enough to help individuals keep appointments.

The AAADs contract with senior centers and/or human resource agencies in their regions to provide transportation services; however, their transportation services are

limited. As the aging population continues to grow, available transportation will continue to be a major need. Addressing the need for transportation of adults age 60 and over and adults with disabilities will require multiple resources. The AAAD

(ADRC) maintains a resource database containing up-to-date and accurate information about community resources that provide transportation.

(2) Administrative Requirements

(a) TCAD shall:

(i) map and update at least annually transportation services available to adults age 60 and over and adults with disabilities;

(ii) review best practice models and work to implement a statewide model that could include door-to-door and door-through-door (assisted transportation or escort) accessibility;

(iii) provide technical assistance to urban and rural communities that are seeking grant opportunities for transportation funding and interface with the National Center for Senior Transportation; and

(b) The AAAD (ADRC) shall:

(i) update at least annually the transportation services that are available including information such as, but not limited to, contact information, hours of operation, and service area and report to TCAD;

(ii) assist organizations and/or agencies to actively recruit, when possible, volunteers who are willing to provide transportation and can be included in the Resource Database with their contact information and times of availability;

(iii) partner with businesses and companies that have an interest in reaching adults age 60 and over and adults with disabilities to develop and implement transportation services to their businesses;

(iv) gather further data on the current and emerging needs on the transportation services in various communities and whether and how those needs are currently being met; and

(v) network with community agencies, organizations, churches, volunteer organizations, and other groups to develop transportation partnerships/ resources.

12-1-.05: Options Counseling

(1) Description of Options Counseling

Options Counseling is a person-centered service that promotes individual informed decision-making about long-term services and supports based on the individual's preferences, strengths, and values. Options Counseling is a critical service of the AAAD (ADRC), serving as a pathway for the individual to access these services. The Options Counseling program is individual-controlled and directed and may include others that the individual chooses or those who are legally authorized to represent the individual. Options Counseling also allows the individual to examine all of the choices available for services, both public and private pay. The Options Counselor guides the individual through the information and choices available.

(2) Components of Option Counseling

Essential components of Options Counseling include:

(a) personal interview that explores and documents the strengths, values, and preferences of the individual;

(b) assistance with the identification of choices available, including personal, public, and private resources;

(c) facilitated decision-support process that explores the resource and service options and supports the individual as he/she examines the pros and cons of various options;

(d) assistance in the development of the individual's written plan of action that serves as a guide for the individual for future actions and identifies the steps necessary to achieve the goals or obtain long-term services and supports that are important to the individual in maintaining independence;

(e) connecting the individual with requested services; and

(f) follow-up to ensure that the supports and decisions are working for the individual by allowing the Options Counselor to follow the progress the individual has

made toward his/her goals, steps in the action plan that have been completed, and any barriers to implementation.

(3) Requirements for Options Counselors

(a) Options Counselors must have:

(i) Bachelors or higher degree; or

(ii) 2-years of employment in I&A or case management for applicants with an Associate Degree; or

(iii) 3-years of employment in I&A or case management for applicants with a High School diploma or GED.

(b) All Options Counselors shall take 16 hours of continuing education annually, such as, but not limited to, on-line courses through the Center for Aging and Disability Education and Research (CADER), Boston University School of Social Work, Boston University as well as seminars and webinars.

(c) All Options Counselors shall have at a minimum the following competencies:

(i) Understand consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services;

(ii) Understand the core roles and functions of an Options Counselor;

(iii) Ability to explain the individual's right of choice and the benefits and risks of self-direction;

(iv) Ability to identify legal and ethical considerations that are involved when working with an individual and his/her family;

(v) Ability to recognize one's own personal bias and judgments when counseling with an individual;

(vi) Ability to recognize the needs, values, and preferences of the individual as a consumer;

(vii) Have interpersonal communication skills to support the consumer in the decision-making process, including decision-making support, effective ways to ask questions while providing resources, active listening, and paraphrasing;

(viii) Seek creative ways to find services and supports; and

(ix) Determine the level of support from family members and their interest in participating and assisting with the problem solving and resources.

(d) Quality Assurance

The AAAD (ADRC) will monitor the following:

(i) the individual's satisfaction with Options Counseling such as assistance with the informed decision-making process;

(ii) the effectiveness in linking people to home and community based services (HCBS);

(iii) the availability of needed services in the community; and

(iv) the progress made in accomplishing the written plan of action.

12-1-06: Services Development

In order to provide effective long-term services and supports and to address the changing needs of the aging and disability populations, especially as the baby boomers and veterans age, the AAADs (ADRCs) need to study trends in service delivery that demonstrate evidence of effectiveness in addressing these changing needs. The following section identifies services and programs that are being developed, have been developed, and/or are being implemented in Tennessee. These services and programs include:

(1) Care Transitions

Care transitions is a process for the coordination and continuity of health care as an individual moves, or transitions, through different locations or different levels of care within the same location; from one healthcare setting to another or to home; and/or between health care practitioners and settings as his/her condition and care needs change during the course of a chronic or acute illness. Each identified shift from care providers and/or settings is defined as a care transition. The individual's care is based on a comprehensive plan of care that should include current information about the individual's goals and preferences, clinical status, logistical arrangements, education of the individual and family, and coordination among the health professionals involved in the transition. Care transitions are essential for an individual with complex care needs.

Through the Centers for Medicare and Medicaid Services (CMS), the Community-based Care Transitions Program (CCTP) has been examining models for improving transitions for individuals going from the inpatient hospital setting to other

care settings, to improve quality of care, to reduce readmissions for high-risk individuals, and to document measurable savings to the Medicare program. The CCTP recognizes that there are multiple factors along the care continuum that impact readmissions and that appropriate interventions at each transition is necessary for reducing readmissions.

(2) Veteran-Directed Home and Community Based Services (VDHCBS)

The Veteran-Directed Home and Community Based Services (VDHCBS) Program is available to veterans of all ages by the U.S. Department of Veterans Affairs and in Tennessee can be accessed through the Veterans Administration Medical Centers. VDHCBS provides the veteran with access, choice, and control over his/her long-term care services, such as hiring his/her own personal care assistants, deciding what combination of services best meets his/her needs, and/or purchasing items and services that will help the veteran live independently in the community. The veteran has a flexible budget for services that may be managed by the veteran or authorized representative to help the veteran continue to live at home or in their community.

(3) Alzheimer's Disease and Related Dementia (ADRD)

Alzheimer's Disease is a devastating disease that directly impacts the individual, the family, the community, and the state. Alzheimer's Tennessee and the Alzheimer's Association stay up-to-date on Alzheimer's Disease and Related Dementia (ADRD) research and related treatments and provide services and programs to meet the constantly changing needs of ADRD individuals and their caregivers. Help lines, care consultation, support groups, advocacy, outreach, education, and many other forms of assistance are provided by these organizations. In addition, the Tennessee Alzheimer's Task Force was created to develop a ten-year State plan that is being implemented in stages.

(4) Dementia Capable

In a dementia capable system, programs are tailored to the unique needs of the individual with dementia stemming from conditions such as Alzheimer's disease and related disorders and the caregiver(s) according to the Administration on Aging (AoA) *Dementia Capability Toolkit* *(http://www.aoa.gov/AoARoot/AoA_Programs/HPW/ALz_Grants/docs/DementiaCapabilityToolkit_12_2_11.pdf)*. The Toolkit identifies topics that should be addressed in the development of a dementia capable system: identifying possible dementia; measuring

functional ability and understanding decision making capacity for care planning and resource allocation; information, referral, assistance, and Options Counseling; support resources for individuals with early stage Alzheimer's disease or related disorder; caregiver support resources; resources for diverse and underserved persons with dementia and caregivers; safety resources; self-directed services; workforce training and tools; and quality assurance systems. To begin to meet the growing need for a dementia capable system, the first step will focus on training for the aging network in Tennessee.

Information & Assistance (I&A)

12-2: Description of Information and Assistance Service

The Information and Assistance (I&A) service was established by the 1973 Amendments to the Older American's Act, Title III, Part B and by the State of Tennessee (T.C.A. 71-5-1418 Long-term care client information, referral and assistance agency). The primary focus of I&A services is on adults age 60 and over, particularly those individuals with greatest social and economic need, and adults with disabilities by:

(1) providing the individuals with current information on opportunities and services available within their communities, including information relating to assistive technology;

(2) assessing the problems and capacities of the individuals;

(3) linking the individuals to available opportunities and services; and

(4) ensuring, to the maximum extent practicable, that individuals receive the services needed by establishing adequate follow-up procedures.

T.C.A. 71-5-1418 "address the need of the State of Tennessee to develop for the future the framework and infrastructure for a comprehensive long-term care system that makes an appropriate place for both institutional care and a broad array of home-based and community-based services (HBCS)". "[T]his section establishes a program that is intended to provide information and assistance on a wide variety of quality, cost-effective and affordable long-term care choices that should be designed to provide data collection and assessment and referral to community-based services and appropriate placement in long-term care facilities." The long-term care client information, referral and assistance program is administered by "the executive director of the commission on aging" and implemented by the area agencies on aging and disability.

12-2-.01 Information and Assistance (I&A) Services and Individual Eligibility

Although I&A services are available to the general public, the primary focus of the I&A services is on adults age 60 and over, adults with disabilities, caregivers, and agencies or organizations seeking information on behalf of an individual. The individual may contact the I&A program through a telephone call, email, and/or personal visit. The services provided through I&A include:

(1) Information

The I&A provides facts and knowledge about specific topics or services to the individual that can range from providing specific contact telephone numbers or addresses for a particular service or program to providing detailed data about community service systems, agency policies, eligibility requirements and/or procedures for application to the ability to connect the individual directly to the requested service through a "warm" transfer. If the counselor is unable to assist the caller, then, while the caller is on the line, the counselor can directly transfer the caller to another agency or organization that will better meet his/her needs. With the "warm" transfer, the counselor can listen to the caller's issue or problem and then can explain to the agency/organization the caller's issue or problem. Prior to the transfer, the counselor will provide the caller with the contact information, in case no one is available to answer the telephone at the other site or the caller is unintentionally cut off during the transfer.

(2) Assessment

During the assessment process, the I&A Counselor assists the individual in identifying his/her problems/needs, evaluating his/her abilities/skills, determining and locating appropriate resources available and providing enough information about each resource to help the individual make an informed choice, and discuss the options currently available to assist the individual. The I&A Counselor will also help the individual, whenever preferred services and/or programs are unavailable, by identifying alternative resources. An initial telephone screening can determine whether or not the individual should be referred for in-home assessment.

(3) Referral

The I&A Counselor will link the individual to the appropriate services as determined by the individual and the I&A Counselor. The referral could be to services

and programs provided by the AAAD as well as community-based agencies and organizations.

(4) Follow-up

The I&A Counselor ensures that the individual receives the services and/or programs needed by establishing adequate follow-up procedures to the maximum extent practicable. The follow-up helps to determine if the information and assistance resulted in a positive outcome and provides program measurement. Follow-up also includes the provision of additional assistance, if needed.

12-2-.02: Administrative Standards for Tennessee Commission on Aging and Disability (TCAD)

TCAD shall:

(1) coordinate a statewide Information and Assistance (I&A) Services.

(2) implement uniform standards for the I&A Services.

(3) compile and analyze the program statistics, and distribute a quarterly statewide report.

(4) comply with applicable federal and state laws, regulations, and policies.

(5) monitor the quality of service delivery and provide the AAAD with a written quality assurance report annually.

(6) provide technical assistance to the AAAD upon request or as determined necessary by TCAD.

(7) sponsor statewide training annually relevant to the provision of information and assistance.

(8) maintain a database for the statewide resource directory annually.

(9) monitor the I&A function of the AAAD to ensure that all of the criteria for operation of the I&A are being met. This includes the following:

(a) The AAAD shall employ, at a minimum, the one-full time equivalent person to be responsible for handling the I&A services.

(b) All staff providing I&A services shall be Alliance of Information and Referral Systems (AIRS) certified or seeking certification after one year of employment.

(c) The AAAD shall maintain an accurate Resource Database in SAMS using the AIRS Taxonomy of Human Services and shall ensure that the Resource Database is updated, at a minimum, annually.

(d) I&A shall collect and report individual demographic data in SAMS.

(e) Satisfaction surveys and follow-up contacts will be reviewed to determine if the individual made contact with the referral(s), if services were provided, and if the services met the needs of the individual.

12-2-.03: Administrative Standards for Area Agencies on Aging and Disability (AAAD)

The AAAD shall:

(1) adhere to the mandated statewide I&A Services that comply with the administrative requirements established by the TCAD

(2) populate, maintain and use an accurate and up-to-date Resource Database that contains information about available community resources and update the Resource Database at least annually

(a) Resources

(i) The State and the AAAD level resource databases shall use the standard service classification system (Taxonomy of Human Services) established by Alliance of Information and Referral Systems (AIRS).

(ii) The AIRS/211 Taxonomy of Human Services provides a framework for common language to bridge differences in terminology used throughout the information and referral industry

(iii) The AAAD resource database must contain, at a minimum, information and/or available services that may be accessed by using the AIRS Categories. See Appendix E for a list of the AIRS Categories.

(iv) Each AAAD shall populate a resource database within the Social Assistance Management System (SAMS). The Resource Database shall be comprehensive in the type of information that it contains. This database shall be updated annually and contain the following information for each entry:

- Resource/Agency Name
- Type of Service
- Business Address (physical location)

- Mailing Address
- Telephone Number
- Fees (if applicable)
- Days/Hours of Operation
- Optional (if available): Email address/Website

(b) Resource Database Criteria

The AAAD shall implement the following criteria when deciding whether or not the agency/organization is entered into the Resource Database. The criteria shall be uniformly published and applied so that all staff and the public will be aware of the scope and limitations of the database.

(i) Inclusion Criteria

All services and programs that focus on adults age 60 and over, adults with disabilities, and their caregivers will be included in the Resource Database, especially those services and programs that provide long-term supports, home and community based services, and a continuum of care and assist the individual in remaining in his/her home as long as possible.

(ii) Exclusion Criteria

- Agencies that deny service on the basis of color, race, religion, gender, nationality, or on any other basis not permitted by law.
- Agencies or organizations that offer or provide services which are unlawful under federal, state or local statue, ordinance, regulation, or order shall be excluded.
- Agencies or organizations that misrepresent, by omission or commission, pertinent facts regarding their services, organizational structure, or any other pertinent matter shall be excluded.

(3) employ, at a minimum, one full-time equivalent person to be responsible for handling the I&A services

(4) provide adequate supervision, office space, equipment and supplies, and administrative support to the I&A Program

(5) provide a telephone system that has the following capabilities:

(i) making a "warm" transfer.

(ii) adjusting the number of rings to a minimum of five (5) before the call rolls over to another trained staff person or, if all staff are occupied, to voice mail during business hours

(iii) rolling the call over to voice mail after business hours; or

(iv) rolling the call over to voice mail after business hours the message on the voice mail shall clearly explain the following:

- what to do if this is an emergency situation; and
- what information is needed for a call back within two (2) business days.

(6) require designated I&A staff to attend all State sanctioned I&A training

(7) monitor and evaluate the quality of service delivery of its I&A contractors at least annually and provide TCAD with a written report of all quality assurance reports during the AAADs annual review

(a) The I&A provider shall employ staff to be responsible for handling the I&A services.

(b) All staff providing I&A services shall be AIRS certified or seeking certification after one year of employment.

(c) The I&A provider shall use Resource Database in SAMS based on the AIRS Taxonomy of Human Services.

(d) I&A provider shall collect and report individual data in SAMS.

(e) The I&A provider shall conduct individual satisfaction survey using a standardized tool in a pre-determined process.

(f) The I&A provider shall conduct a follow-up contact with the individual to document whether or not the individual made contact with the referral(s), if services were provided, and if the services meet the needs of the individual.

(8) develop a plan for a private pay option

In order to expand access to services beyond those provided by the traditional services funded by federal OAA or funded by state Options, a private pay option shall be developed for individuals who have the means to pay with private funds. The development of a private pay option will increase the available service options to adults age 60 and over and adults with disabilities, regardless of income level or method of payment. The AAAD (ADRC) may serve the individuals in

the private pay option in the capacity of care management or support broker to connect the individual with needed services.

(9) build cooperative partnerships

(a) Each AAAD shall identify and form partnerships with regional information and referral service providers, other agencies or organizations that might refer people to the AAAD and show evidence of partnerships developed through:

(i) face-to-face meetings to share information and develop a working relationship, or

(ii) joint projects, or

(iii) signed formal agreements, as appropriate (such as contracts, Memorandums of Understanding, or Memorandums of Agreement)

(b) Examples of potential information and referral and information and assistance partners may include, but shall not be limited to: Tennessee Disability Pathfinder (www.familypathfinder.org), 2-1-1, Ask-A-Nurse, Crisis Hotlines, Senior Centers, Health Assist Tennessee, Department of Human Services, Adult Protective Service, Crisis Intervention Agencies, Hospitals, Alzheimer's Association, Centers for Independent Living, Tennessee Department of Health, Family Support Program, Employee Assistance Programs, AARP, ARC of Tennessee, Tennessee Disability Coalition, service providers, etc.

(8) recommended by TCAD that each AAAD become a member of the national organization Alliance of Information and Referral (AIRS).

The mission of AIRS is to provide leaderships and support to advance the capacity of a Standards-driven Information and Referral industry that brings people and services together. AIRS develops clear and consistent professional standards that benchmark every aspect of a quality I&R. AIRS membership is available for all I&R providers. AIRS has three (3) levels of membership: Basic, Standard, and Premium. The AIRS website identifies the cost of each membership level and the membership benefits for each level. The organization may select its level of membership based on the benefits provided at each level.

12-2-.04: I&A Service Standards

This section describes the Tennessee standards for all aging and disability network I&A staff, services to be provided, and the protocols for delivering the support services that must be implemented by the provider of the Information and Assistance (I&A) Service.

(1) Staffing

(a) Alliance of Information and Referral Systems (AIRS) Certification

All staff providing I&A services must become an AIRS Certified Information and Referral Specialist-Aging. AIRS is an international membership association for professional information and referral providers that offers AIRS training and accreditation in providing information and referral. The complete and most current AIRS Standards may be found at www.airs.org. A summary of the AIRS Standards may be found in Appendix F.

AAAD staff must apply to take the AIRS Certification exam once they are eligible. Eligibility is based on information and referral and equivalent experience combined with educational background. To take the AIRS certification exam, the AAAD staff must have the following education and experience:

(i) At least one year of employment in information and referral for applicants with a Bachelor's or higher degree

(ii) Two years of employment in information and referral for applicants with an Associates/Community College degree

(iii) Three years of employment in information and referral for applicants with a high school diploma or GED

(iv) The staff member must pass the AIRS Certification Examination and become an AIRS Certified Information and Referral Specialist-Aging within one year from his/her eligibility date in order to continue work in I&A services. Tennessee program standards for I&A shall follow the standards of the Alliance of Information and Referral Systems (AIRS).

(b) I&A Staff Competencies

The qualifications and certification for the I&A Specialist are identified in

12-2-.03(1). In addition, the I&A Specialist shall have the following competencies:

(i) Ability to meet the needs of people who are angry and hostile, are manipulative, call frequently with the same problem, or are otherwise difficult to serve.

(ii) Ability to meet the needs of special populations (i.e., adults age 60 and over, individuals with dementia, and adults with disabilities).

(iii) In cases of domestic violence and other crisis situations, to take special precautions to safeguard the individual's identity and all aspects of the interview.

(iv) Use appropriate disability language.

(v) Use the resource database to create records of calls/contacts and accurately enter data for each inquiry in SAMS.

(vi) Offer unbiased information about public and private services in the region.

(vii) Provide accurate and up-to-date information and resources in a manner consistent with the individual's level of understanding;

(viii) Provide information and assistance services in a manner that respects the values, origin, age, and background of the individual.

(ix) Continuously update and maintain a database of information and referral sources.

(x) Follow-up with individuals who are at risk and/or vulnerable and in situations where the I&A Specialist believes that the individual cannot follow through and resolve his/her problems according to AIRS Standard 6 for appropriate procedures.

(xi) Assist with developing cooperative relationships with other local information and referral agencies, the local service delivery systems and regional and state associations.

(c) Staffing and Training

(i) At a minimum, each AAAD shall employ one qualified I&A Specialist crossed trained in SHIP to provide backup for vacation and sick days, lunch hours, etc.

(iii) Staff development and training shall include required maintenance of certification and other training mandated by the State Agency.

(2) Support Services Protocol

Support services are essential for providing information and referral and assuring access for adults age 60 and over and adults with disabilities, including a brief assessment of need; a blend of information, referral and advocacy in order to link the client to the appropriate service; crisis intervention, when warranted; and follow-up, as required. The following sections describe the required support system that must be in place for the delivery of I&A services

(a) Returning Calls

Calls that are captured on voice mail or by the answering service shall be returned within two (2) business days.

(b) Internet Contact

Individuals using the internet to access I&A shall receive an e-mail response or follow-up call within two (2) business days.

(c) Office Visits

Office visits may, or may not, be scheduled ahead of time, but individuals seeking I&A should be treated the same. The I&A Specialist shall not receive calls while the individual is being served.

(d) Confidentiality

Confidentiality respects the individual's privacy by limiting access to and/or placing restrictions on an individual's personal information. The following ensures individual confidentiality:

(i) Sharing individual information shall always be with the permission of the individual and on a "need to know" basis. Identifying information shall not be disclosed to other AAAD staff unless there is sufficient reason to do so.

(ii) Computers shall face away from doorways or have filters that block visibility to anyone other than the staff member using the computer.

(iii) Computers shall not be left unattended when individual information is

displayed on the computer monitor.

(iv) Each AAAD shall designate staff that shall have access to the individual information.

(v) AAAD staff and volunteers working with individual information shall sign statements of confidentiality upon employment or start of service and annually thereafter.

(e) Electronic Files

(i) Electronic individual files shall be backed up and archived for six (6) years following termination of the service(s) and, if still inactive at the end of the six (6) year period, shall be deleted.

(ii) An individual file may be held as an electronic file or hard copy, but need not be both.

(iii) If the AAAD maintains hard copies of the individual files, the following rules apply:

- Hard copy of individual files shall not be left unattended at any time.
- Hard copy of individual files shall be stored in locked file cabinets or locked rooms when not in use.
- Hard copy files of an individual who is no longer enrolled in a service(s) shall be kept for six (6) years following termination of the service(s) and, if still inactive, shall be shredded.

(f) Call Log

All telephone calls must be recorded in SAMS database.

(g) Crisis Intervention

Crisis intervention is not the primary focus of the I&A service through the ADRC; however, I&A Specialists shall be prepared to handle any call that comes in through the I&A service. This includes assistance for the individual threatening suicide, homicide, or assault; suicide survivors; victims of domestic abuse or other forms of violence; child abuse/neglect or elder/dependent adult

abuse/neglect; sexual assault survivors; runaway youth; psychiatric emergency, chemically dependent in crisis; survivors of a traumatic death; and others in distress.

(i) The I&A Specialist shall have the interventions skills to:

- de-escalate and stabilize the individual and help him/her remain calm;
- help the individual talk about and work through his/her feelings as part of the assessment and problem solving stages of the interview; and
- endeavor to keep the individual on the telephone pending referral or rescue.

(ii) The I&A Specialist shall have the skills to recognize the warning signs of imminent risk.

(iii) The I&A Specialist shall have the skills to recognize when an individual is in need of immediate intervention and shall follow the I&R service's rescue protocol for accessing 911 or other emergency personnel.

(iv) In cases of suspected child or elder abuse, the I&A Specialist shall be familiar with his/her responsibilities under the prevailing legislation of the jurisdiction regarding mandatory reporting and shall file a report when indicated.

(h) Follow-Up

The AAAD shall conduct a follow-up call with the individual within seven (7) business days following the referral to an agency or organization for services to determine if the individual actually made contact with the agency or organization and whether or not services were received.

Appendix A

ADRC Fully Functioning Criteria

Aging & Disability ResourceCenter
TECHNICAL ASSISTANCE EXCHANGE

Criteria of Fully Functioning Aging and Disability Resource Centers

March 2012

These criteria were developed to assist states and stakeholders to measure and assess state progress toward developing fully functioning Aging and Disability Resource Centers (ADRCs), sometimes referred to as "single entry point" or "no wrong door" systems for long term services and supports. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. The term "ADRC" in this document may be interpreted to represent one organization in each community, a network of operating organizations or operating partners in each community, or a combination of state level and local level organizations operating in partnership to serve the entire state. Metrics that should be interpreted or applied differently to different types of ADRC models are noted.

If there is one a single organization designated as the ADRC and serving as the single entry point in a designated area, that one organization must provide or contract with others to provide all the ADRC functions for all populations. If there are multiple organizations designated as ADRC operating partners providing multiple entry points in a designated area, each organization does not necessarily need to perform every function for all populations. It is the combination of the organizations' highly coordinated efforts which results in a fully-functional ADRC.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
Information, Referral and Awareness	The *Information, Referral and Awareness* function of an ADRC is defined by the ADRC's ability to serve as a highly visible and trusted place where people of all ages, disabilities and income levels know they can turn for objective and unbiased information on the full range of long-term service and support options. It is also defined by its ability to promote awareness of the various options that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to plan ahead for their long-term needs. Finally, ADRCs should have the capacity to link individuals with needed services and supports – both public and private - through appropriate referrals to other agencies and organizations.	<u>Outreach and Marketing</u> • ADRC has a proven outreach and marketing plan focused on establishing operating organizations as highly visible and trusted places where people can turn for the full range of long-term support options as well as raising awareness in the community about long term service and support options. The outreach and marketing plan includes: 1. Consideration of all the populations they serve including different age groups, people with different types of disabilities, culturally diverse groups, underserved and unserved populations, individuals at risk of nursing home placement, family caregivers and professionals; 2. A strategy to assess the effectiveness of the outreach and marketing activities; and 3. A feedback loop to modify activities as needed. • ADRC actively markets to and serves private pay individuals in

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
		addition to those that require public assistance. Information and Referral • ADRC uses systematic processes across all operating organizations to provide information and referral/ assistance. • ADRC consistently conducts follow-up with individuals receiving I&R/A to determine whether more assistance is needed. • Whether the ADRC has single or multiple operating organizations in the service area, all organizations use the same comprehensive resource database with information about the range of long term supports and resources in the service area and: 1. A system is in place for updating and ensuring the accuracy of the information provided; 2. Resources in the database conform to established inclusion/exclusion policies; these policies specifically address inclusion of resources and providers for private paying individuals and families; and 3. The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities.
Options Counseling	The Options Counseling function is defined by the ADRC's ability to provide person-centered one-on-one assistance and decision support to individuals and others they may wish to include in the process such as family members and/or caregivers/support persons. The main purpose of Options Counseling is to help individuals understand and assess their situation, assist them in making informed decisions about long-term service and support choices in the context	Options Counseling • Standards and protocols are in place that define what options counseling entails and who will be offered options counseling based on draft national Options Counseling standards. At a minimum, this will include any individual who requests it and individuals who go through a comprehensive assessment. Options Counseling should be incorporated into all state and local rebalancing efforts, systems integration activities, transition supports activities, and participant-directed programs.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	of their preferences, strengths, and values. Options Counseling also entails working with individuals to develop action plans and, if requested, arranging for the delivery of services and supports, including hiring and supervising their own direct service workers. Individuals and families who receive options counseling should be able to make service and support choices that optimally meet their needs and preferences, and use their own personal and financial resources more efficiently and more effectively.	• ADRC has the capability, through one or multiple operating organizations, to provide objective, accurate and comprehensive long term support options counseling to individuals of all income levels and with all types of disabilities. • All ADRC operating organizations that serve as entry points for individuals use standard intake and screening instruments. • Options counseling sessions are conducted by staff trained and qualified to provide objective, person-centered assistance and decision support to individuals, as evidenced by certification, minimum qualifications and/or training/cross-training practices. • ADRC provides intensive support to individuals in short-term crisis situations until long term support arrangements have been made. • ADRC consistently conducts follow-up with individuals receiving options counseling to determine the outcome and whether more assistance is needed. • ADRC provides individuals and families with assistance in planning for future long term support and service needs directly or contractually by staff that possess specific skills related to LTSS needs planning and financial counseling.
Streamlined Eligibility Determination for Public Programs	Long-term services and supports are funded by a variety of different government programs administered by a wide array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. The Streamlined Eligibility Determinations for Public Programs component of an ADRC is defined by its ability to serve as a single point of entry/no wrong door, to all publicly funded long-term supports, including those funded by Medicaid, the Older Americans Act (OAA), the	<u>Intake and Screening</u> • ADRC has a standardized process for helping individuals access all publicly-funded long term services and supports programs available in the state. • In multiple entry point systems, the intake and screening process is coordinated and standardized across operating organizations and key partners so that individuals experience the same process wherever they enter the system. <u>Financial and Functional Eligibility Processes</u>

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	Rehabilitation Services Act, and other state and federal programs and services. This requires ADRCs to have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to performing the following administrative functions for all public programs (including both home and community-based services programs and institutional-based programs): • consumer intake • screening • assessing an individual's needs • determining programmatic, functional/clinical and financial eligibility • developing service/care plans • ensuring that people receive the services for which they are eligible The goal is to create a process that is both administratively efficient and seamless for individuals regardless of which program they end of being eligible for or the types of services they receive.	• Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by the ADRC, so individuals experience it all as one process. • ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk. • Staff located on-site within the ADRC conduct level of care assessments that are used for determining functional/clinical eligibility, or ADRC has a formal process in place (e.g. MOUs, written protocols) for seamlessly referring individuals to the agency that conducts level of care assessments. • ADRC staff assist individuals as needed with initial steps in completing the application (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews). • Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of applicants. <u>Tracking Eligibility Status</u> • ADRC is able to track individuals' eligibility status throughout the process of eligibility determination and redetermination. • ADRC is routinely informed of individuals who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals to provide further options counseling. • In localities where waiting lists for public LTC programs or services exist, the ADRC is routinely informed of individuals who

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
		are on the waiting list and conducts follow-up with those individuals.
Person-Centered Transition Support	The Person-Centered Transitions component is defined by an ADRC's ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person ends up in a nursing home or is transitioned back to their own home. The ADRC can play a pivotal role in these transitions to ensure that people understand their options and receive long term services and supports in the setting that best meet their individual needs and preferences, which is often in their own homes. ADRC staff can be present at these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and to help them quickly arrange for the supports and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a nursing home or other institution. They can also break the cycle of readmission to the hospital that often occurs when an individual with chronic illness is discharged to the community	• ADRC has formal agreements with local critical pathway providers such as hospitals, physician's offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and ICFs-MR that include: (1) An established process for identifying individuals and their caregivers who may need transition support services; (2) Protocols for referring individuals to the ADRC for transition support and other services; and (3) Regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations. • ADRC works with the State Medicaid Agency to serve as Local Contact Agencies (LCAs) to provide transition services for institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	without the social services and supports they need.	
Consumer Populations, Partnerships and Stakeholder Involvement	Many ADRCs started out serving older adults and one other target population, such as adults with physical disabilities, intellectual or developmental disabilities, or mental illness. ADRCs should work toward the goal of serving persons with all types of disabilities regardless of age. To be truly person-centered, ADRCs must meaningfully involve stakeholders and individuals they serve in planning, implementation and quality assurance/quality improvement activities. In order to function efficiently and serve as the single entry point / no wrong door for the full array of long term service and support programs in the state, ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving people with disabilities. Examples of other important state partnerships could include the State Health Insurance Assistance Program (SHIP), Brain Injury Associations, and the State Mental Health Planning Councils. ADRCs should be operated by or establish strong local partnerships with Area Agencies on Aging, Centers for Independent Living, and other community-based organizations instrumental to ADRC activities such as Departments of Veterans Affairs, Adult Protective Services, Information and Referral/2-	<u>Consumer Populations</u> • ADRC serves individuals with all types of disabilities, either through a single operating organization or through close coordination with multiple operating organizations. • ADRC staff demonstrates competencies relating to serving people of all ages and types of disabilities and their families, including people with dementia and people of different cultures and ethnicities. • There are formal mechanisms for involving consumers on state/local ADRC advisory boards or governing committee and in planning, implementation and evaluation activities. <u>Medicaid</u> • ADRC has formal partnership agreements at the local level (or at the state level if applicable across all sites) with Medicaid agency(ies) that describe explicitly the role of each partner in the eligibility determination process and information sharing policies. • ADRC staff are involved as partners or key advisors in other state long term support and service system reform initiatives (e.g. Money Follows the Person initiatives) <u>Aging and Disability Partners</u> • In multiple entry point systems, the ADRC has formal service standards, protocols for information sharing, and cross-training across all ADRC operating organizations. • In single entry point systems, there is strong collaboration, including formal agreements, at the state and local levels between the ADRC and all other critical aging and disability agencies and service organizations serving the same area that

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	1-1 programs, Benefit Outreach and Enrollment Centers, One Stop Employment Centers, Vocational Rehabilitation, Developmental Disabilities Councils, Long-Term Care Ombudsman programs, Alzheimer's disease programs, housing agencies, and transportation authorities.	are not ADRC operating organizations. Other Partners and Stakeholders • State Health Insurance Assistance Program (SHIP), Adult Protective Services, and 2-1-1 programs are operated by the ADRC, or there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals between the ADRC and these three programs. • ADRC operating organizations (e.g., AAA or SUA) have a Provider Agreement with a VA Medical Center to provide Veteran-Directed HCBS or there is a formal agreement at the state or local level between the ADRC and VA system outlining a protocol for linking Veterans with needed long term services and supports and making mutual referrals. • There is evidence of strong collaboration with other programs and services instrumental to ADRC activities.
Quality Assurance and Continuous Improvement	Quality Assurance and Continuous Improvement are a part of every ADRC system to ensure services are available, are of high quality and meet the needs of individuals, and are sustained statewide. They ensure that services adhere to the highest standard, as well as ensure the public and private investments in ADRCs are producing measurable results. ADRCs should be using electronic information systems to track their customers, services, performance and costs, and to continuously evaluate and improve on the results of the ADRC services that are provided to individuals and their families, as well as to other organizations in the community. This may include linkages with other data systems, such	Sustainability • State operates in accordance with a formal written plan (e.g., the ADRC 5-Year Plan) that details how ADRC services will be made available statewide and sustained through a diverse set of public and private funding sources. Management and Staffing • In multiple entry points systems, the ADRC has one overall coordinator or manager with sufficient authority to maintain quality processes across operating organizations. • ADRC has adequate staff capacity to assist individuals in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. IT/MIS • ADRC operating organizations use management information

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	as Medicaid information systems and electronic health records. The Quality Assurance and Continuous Improvement component of an ADRC should also involve formal processes for getting input and feedback from individuals and their families on the ADRC's operations, services used, and on-going development. Every ADRC should have measurable performance goals and indicators related to its visibility, trust, ease of access, responsiveness, efficiency and effectiveness.	systems that support all program functions. • ADRC has established an efficient process for sharing resource and client information electronically across ADRC operating organizations and with external entities, as needed, from intake to service delivery. <u>Continuous Improvement</u> • ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered such as consumer satisfaction evaluations and surveys. • ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. <u>Performance Tracking</u> • At the local or programmatic level, ADRC routinely tracks service delivery and individual outcomes and can demonstrate: 1. That the ADRC serves people in different age groups, with different types of disabilities and income levels in proportions that reflect their relative representation in the community; 2. That options counseling provided enables people to make informed, cost-effective decisions about long-term services and supports; 3. The number of individuals diverted from nursing home/institutional settings; and 4. The number of individuals successfully transitioning from institutional settings (i.e. number of people assisted through formal coordinated or evidence-

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
		based transitions programs). • States evaluate their ADRCs' overall impact in the following areas: 1. Reduction in the average time from first contact to eligibility determination (both functional/clinical and financial) for publicly funded home and community-based services; 2. Impact on the use of home and community based services vs. institutional services; and 3. Documentation of the cost impact to public programs, including Medicaid.